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STEMMING THE TIDE:
HEALTHIER JOBS TO TACKLE ECONOMIC INACTIVITY

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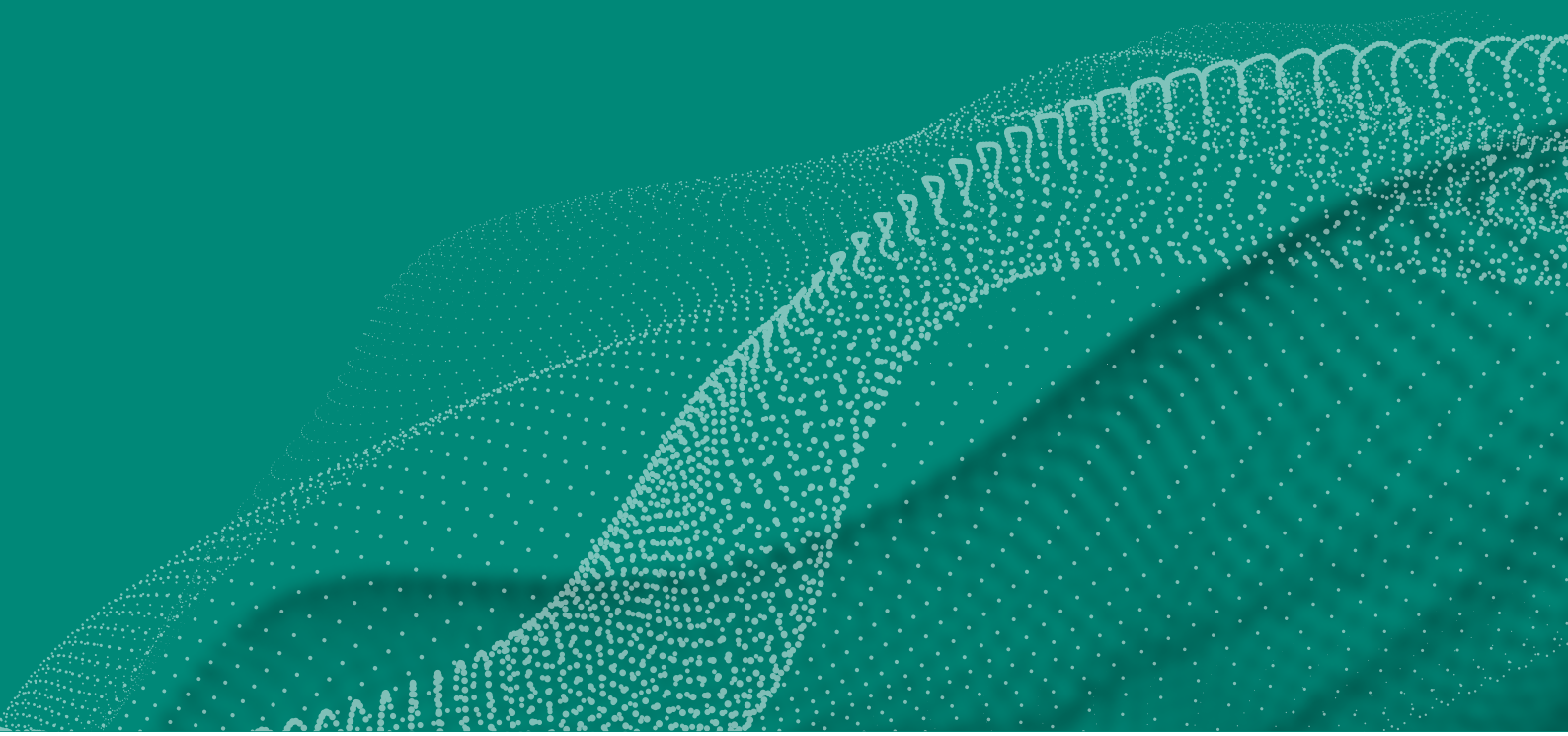

Centre for Organisational Health & Well-being | Lancaster University

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The Centre for Organisational Health & Well-being is based at Lancaster University in the UK. It is an inter-disciplinary centre aiming to support employers, policymakers and other key stakeholders to develop sustainable, healthy work and healthy workplaces. The Centre brings together expertise from the Faculty of Health & Medicine, Lancaster University Management School, and the Work Foundation to address challenges associated with the changing nature of work and achieve its aim.

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EXECUTIVE SUMMARY

The new Government has set an ambitious target to raise the employment rate to 80% – which would represent an increase of approximately 2.4 million more people in work than today. Achieving this target is critical to the Government's wider goals of growing the economy, balancing the public finances and improving living standards across the country.

However, in reality, the UK faces a number of health-related workforce challenges that will make realising this ambition particularly difficult. Since the beginning of 2020, the number of people who have left the labour market altogether due to long-term illness has risen by 671,000, and now sits at a near record 2.78 million. At the time of publication, the UK remains the only G7 country with a smaller workforce than before the Covid-19 pandemic.

And while the pandemic may have accelerated the rate at which people have left the labour market during this period, evidence suggests that the decline in health among the working age population is a longer-term trend that will continue

In response, the Government has launched a new 'Get Britain Working' White Paper, with a primary focus on boosting support and work incentives for those who have fallen into economic inactivity – including interventions for those with long-term illnesses and a review to understand how employers can support workers to stay in employment. But until the Keep Britain Working Review reports in Autumn 2025, there remains a significant policy gap as to how to stem the flow of those leaving the labour market due to ill health in the first place.

This study aims to provide new evidence, insights and policy direction for how Government and employers can work together to help retain more people who experience health issues in employment. It features a longitudinal analysis of the employment journeys of 9,169 workers aged 16-60 from 2017/18 to 2021/22 using the Understanding Society dataset to shed light on who is leaving the labour market due to ill health and factors that influence the risk of falling into economic inactivity. It also draws on a survey of over 1,000 senior business leaders across Great Britain and roundtable discussions with employers and policymakers on the challenges and opportunities to support healthier working lives.

Health issues and inflexible workplaces are driving people to exit the labour market early and many struggle to return to employment

Analysis of Understanding Society data reveals the extent to which health issues and job design are contributing to the rising tide of working-age people leaving the labour market. Nearly one in ten (9%) employees in the study who experienced a health issue between 2017-19 had become unemployed or exited the labour market altogether by 2021-22. Nearly half of this attrition happened in the first year, when 4.2% people left their job following a health decline. This indicates that once access to short-term sickness absence interventions end – such as sick pay – many people are unable to stay in their job, and in some cases, become economically inactive.

Workers with multiple health conditions are especially vulnerable to the risk of early workforce exit. Those with three or more conditions are 5.6 times more likely to leave work than those without a health condition or disability. Mental health also plays a key role in the chances of individuals leaving work. Employees with poor mental health are nearly twice (1.9 times) as likely to leave work following the onset of illness than those who report good mental health.

Once workers with ill health leave work, they can struggle to return. The Department for Work and Pensions calculated in 2021 that only half of people who experience a health decline and leave work will return to employment within five years.

Employers understand the challenges but are struggling to respond

The majority of businesses in the UK understand the impact that poor employee health can have on their organisations, and the negative workforce outcomes factors such as work intensification, job insecurity, stagnating wages, and long working hours lead to. Two thirds of senior business leaders (64%) state that poor employee health has a detrimental effect on their organisation's economic

performance, with 44% identifying absenteeism due to ill health as a serious issue. However, many employers display an 'awareness to action gap' when it comes to addressing these problems.

New findings show that a pivotal factor that can enable people to remain in work after a health setback is flexibility and control over key parts of their job. Workers without any flexibility are four times more likely to leave work, while those with low levels of control over working hours, pace, tasks, order and work manner are 3.7 times more likely to exit.

In addition, having high levels of control over at least one aspect of work reduced the chances of leaving employment by nearly three quarters. For women who experience ill health, a lack of control over the order of tasks increases their likelihood of leaving employment by 2.4 times. Whereas for men, control over how they perform tasks is even more important – those without it are five times more likely to leave work.

Yet despite this, less than half (48%) of employers surveyed offer flexible working arrangements. Only a third are putting in other upstream measures to prevent ill health, such as assessing workplace mental health risks and implementing adjustments to manage workload, work pace and role clarity.

When it comes to providing proactive support to those with health conditions, three in five (65%) business leaders acknowledged the importance of occupational health, yet just 37% provide these services. There is a particular gap between large employers (250+ employees) who are more likely to offer occupational health services than SMEs (47% versus 30%).

The need for a national reset on workforce health to keep Britain working

Unlike other nations, the UK Government has not taken a proactive approach to worker health, leaving employers to make their own decisions with little coordination of occupational health interventions. In comparison, countries such as Germany, Denmark and the Netherlands make occupational health provision mandatory and have close to universal coverage amongst their workers.

Likewise, when workers become ill, the UK's Statutory Sick Pay paid by employers replaces just 17% of average weekly earnings making it among the least generous in the OECD – and almost half of employers (47%) do not go beyond the statutory minimum level of sick pay provision. In contrast, employers in the Netherlands are mandated to provide sick pay of at least 70% of worker's wages for up to two years of an absence and provide rehabilitation programmes.

In a context where the number of working-age people living with major illness is forecast to grow, it is clear that the UK's current systems do not adequately focus on prevention and early intervention to support people experiencing ill health to remain in employment.

To reach an 80% employment rate – or even get close – Government must work together with employers to adopt a new policy framework that aims to:

- Protect workforce health
- Increase employment retention and reduce pressure on the welfare system
- Achieve a sustainable sharing of responsibility between employers and the state

Recommendations:

The Government must act quickly to establish a cross-departmental agenda on workforce health which lays out a roadmap to implement a series of upstream, midstream and downstream measures that support more people to remain in healthy, sustainable employment. Measures should include:

1. **Upstream action – to improve job quality and strengthen health forecasting, Government should:**

- Ensure the Employment Rights Bill enshrines secure and flexible working from day one of employment
- Enhance and enforce breaks and paid leave entitlements to meet the evolving needs of the workforce in accordance with the rising pension age
- Revise the Health and Safety Work Act etc 1974 to reflect current modern workforce challenges, including psychosocial risks and mental health issues, and enhance enforcement of mental health risk assessments and preventive measures
- Improve forecasting and monitoring of workforce health by modernising data.

2. **Midstream action – to develop a roadmap for transformed occupational health services and integration with public health, Government should:**

- Lead a strategic transformation of occupational health services focussed on improved and extended coverage for all workers, with mandatory provision by large employers
- Establish a UK-wide network of one-stop workforce health hubs, offering funded SME services and integrated with public health initiatives.

3. **Downstream action – to prevent exclusion of long-term sick employees from the workforce, Government should:**

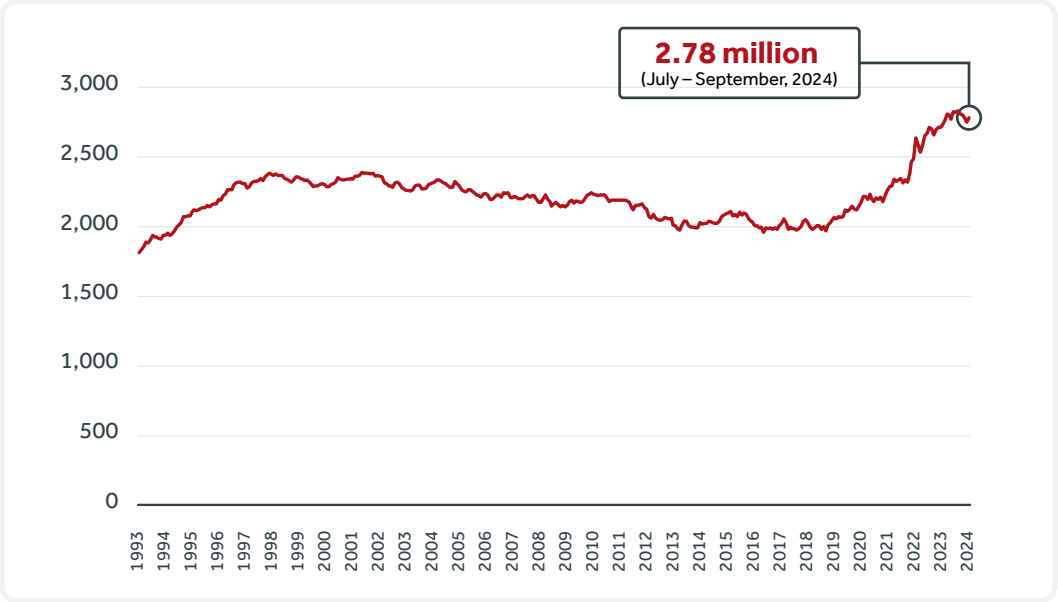
- Increase Statutory Sick Pay (SSP) to promote retention
- Examine practicalities of extending the duty of care for employers and incentivising vocational rehabilitation
- Test feasibility of partial wage subsidy and SSP rebate schemes to offset employer costs associated with long-term sickness.

1. INTRODUCTION

How to tackle the sustained rise of economic inactivity due to ill health is one of the profound challenges facing the new Government.

The rate of unemployment in the UK may be historically low at just 4.3%,[1] but this figure risks masking a much more significant labour market participation crisis that has unfolded in recent years. Since the beginning of the Covid-19 pandemic, an additional 671,000 working-age people in the UK have left the labour market due to long-term sickness, with the total number now standing at a near record 2.78 million.[2]

Figure 1: Change in economic inactivity due to long-term sickness in the UK, for people aged 16 to 64 years old, thousands



Source: Work Foundation analysis of ONS Labour Force Survey dataset on Economically inactivity reasons: Long-term Sick: UK: 16-64:000s :SA.

While the pandemic may have accelerated the rate at which people have left the labour market due to long-term sickness, the decline in health amongst the working age population is a longer-term trend.[3] Since 2011, UK life expectancy has plateaued after decades of steady improvement, and in 2020, the Covid-19 pandemic saw it fall further with no recovery since.[4] A growing body of research is exploring whether this decline in working age health is being compounded by labour market factors such as the impact of stagnating wages on living standards, increased work intensification, work insecurity and the rising retirement age.[5, 6, 7, 8]

In addition, the kinds of conditions keeping people out of the labour market underline how challenging it will be to reverse this trend. Data suggests that over 1.35 million (53%) of those inactive due to long-term sickness in 2023 were suffering from depression, bad nerves or anxiety.[9] A significant proportion of those deemed economically inactive report suffering from multiple conditions. Moreover, while the number of disabled people in employment increased by 310,000 over the last year, the number of working-age disabled people increased by more (580,000), meaning there has been no statistically significant improvement in the disability employment rate.[10] The disability employment gap was 28.6 percentage points, and the disability economic inactivity rate was 43.1% in April – June 2024.[11]

Older people are leaving the workforce faster than younger workers.[12] The biggest increase in economic inactivity due to ill health being was among people over the age of 50. Among women, ill health has taken over as the main driver of economic inactivity, whilst historically it has been caring for the home and family.[13] These factors interact, with an increasing number of people now balancing employment with caring responsibilities.

Pressure building on the public finances and worker shortages

This rise in health-related economic inactivity has put substantial pressure on the welfare system – with real-terms spending on health-related benefits having risen by £12 billion between 2019/20 and 2023/24 – and is contributing to worker shortages, which impacts the Government's ambitions to grow the economy.[14] The UK remains the only country in the G7 with a smaller workforce than prior to the pandemic period.

In response, the Government has set itself the target of achieving an employment rate of 80% – up five percentage points or 2.4 million people from where it lies today.[15] To support this effort, the Department for Work and Pensions has pu a 'Get Britain Working' White Paper, expected to contain a host of long-term, strategic measures to support more people who have left the labour market to return with a greater role for local government.

But to truly resolve this issue, the Government review must also ask three additional questions. First, how can we prioritise the *prevention* of workforce ill health in the first place, including through job design and wider labour market regulation? Second, how can we *stem the flow* of people leaving the labour market if and when they experience ill health? And third, if we are able to support someone to return to work, how can we ensure they *remain* in sustainable employment?

This paper explores the role that Government and employers themselves must play in addressing these challenges.

Increasing the focus on policies to boost worker retention

Over the last three decades, successive governments have invested billions in a range of welfare to work programmes and benefit reforms focussed on getting people back to work. In some cases, these initiatives have recorded some successes. For example, New Labour's Pathways to Work Programme, was found to increase the number of people moving into work by eight percentage points.[16] However, the current welfare system has faced substantial criticism for taking an overly punitive stance and offering a patchwork of support that fails to meet the specific needs of welfare claimants.[17,18]

These interventions have also done little to address the root causes of workers falling out of work in the first place – such as the underlying quality, security and flexibility of work, or the provision of health-related support on offer. This is significant as the UK Insecure Work Index 2024 highlights that one in five workers in the UK face severe insecurity at work, including a mix of low pay, unpredictable hours, poor protections, and limited career progression.[19]

Evidence suggests these kinds of jobs can have a detrimental impact on the health of workers. A separate Work Foundation study found that workers in these roles were 1.4 times more likely than those with secure jobs to become unemployed or economically inactive due to ill health between 2019 and 2023.[20] This suggests that job security could be a factor in whether someone will stay in employment while managing a long-term health condition.[21]

Likewise, there are significant gaps in the kinds of health-related support offered by many UK employers. For example, employers are less likely to provide access to occupational health services than those in other countries, which combined with other factors such as the UK's low rate of Statutory Sick Pay (which replaces just 17% of average incomes) means many workers who become unwell may feel they have no choice but to leave work altogether.[22]

It is also increasingly clear that legislation such as the Health and Safety at Work etc Act 1974 – which remains a cornerstone of workplace regulation 50 years on – needs updating to ensure employer responsibilities reflect the evolving challenges of today's workforce. For example, while in previous decades physical injuries were a leading causes of sickness absence, today mental health issues – such as stress, depression, and anxiety – account for 17.1 million of days lost to ill health, while musculoskeletal disorders account for 6.6 million.[23]

The Health and Safety Executive (HSE) is building an evidence base to guide policy decisions that can help employers prevent and mitigate work-related stress, which is a welcome development.[24] But despite the significant increase in mental health-related absences, most employers are not yet taking proactive steps to identify the causes in order to mitigate these risks in a preventative manner.

What is the role of employers and Government in keeping people in work before they become inactive or unemployed?

Recent policy shifts indicate that Government recognises that the nature of employment itself, and the choices and policies that employers themselves pursue, have a substantial impact on the likelihood of individuals suffering with health issues remaining in the workforce.

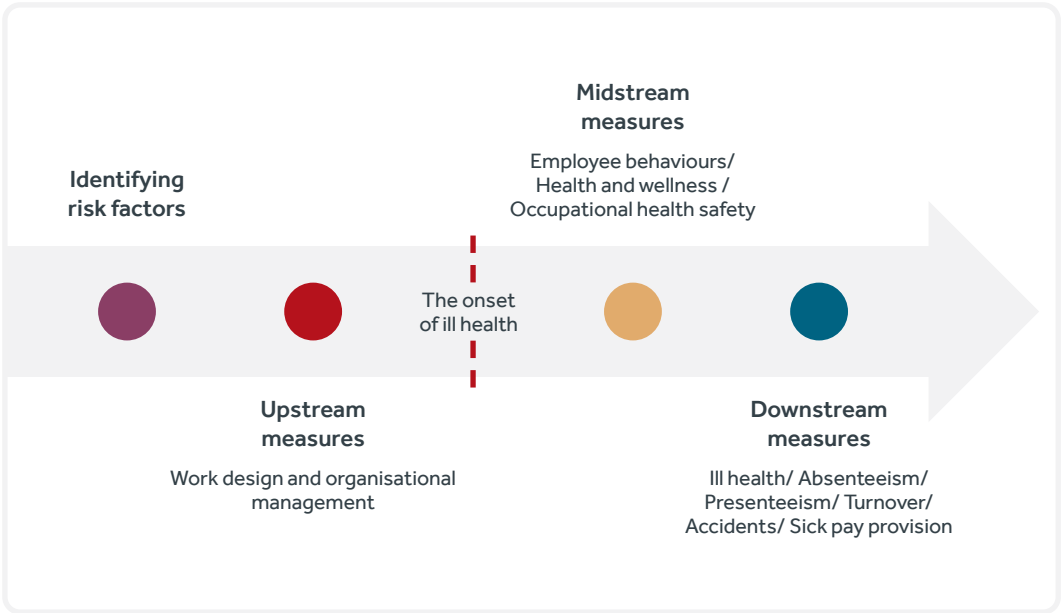
The Employment Rights Bill – which promises to abolish exploitative zero-hour contracts, improve contractual security and enhance access to flexible working and Statutory Sick Pay – is a step in the right direction. However, its provisions may yet be introduced in such a way that it falls short of substantially enhancing the control and predictability that people have in their working lives.

And while there appears to be a greater interest from Government in investing in preventative interventions to both improve population health and enable more people to work whilst managing health conditions, there is still little detail on how it plans to do so.

This paper seeks to add to the evidence available to policymakers and employers as they grapple with these challenges. It employs a mixed-methods approach that includes a longitudinal analysis, an employer survey, employer conversations and an employer roundtable. It aims to address the complex challenges arising from increased health-related economic inactivity for Government, employers and workers themselves, and examines the most effective forms of preventative action and support for maintaining employment among those with health issues.

Moving towards a proactive policy framework- emphasising upstream interventions, such as preventive workplace health measures will be crucial in reversing this trend.[25]

Figure 2: Different measures of healthy work interventions (Stavroula Leka)



2. METHODOLOGY

The methodology of this research employs mixed methods, combining quantitative and qualitative elements:

1. **Literature review:** This includes framing current challenges within the broader academic and policy context. Insights from the literature review shaped the research questions and report structure.

2. **Longitudinal data analysis:** Using the UK Understanding Society dataset 2017/18 to 2021/22 to examine the extent to which negative health transitions can affect people's employment, the analysis compares the employment status of employees reporting a deterioration in health to those with a positive, or no change in health status, following the methodologies employed in a 2021 Department for Work and Pensions report.[26]

   The study looks at movements from employment into three types of worklessness:

   - Unemployment (active job seeking)
   - Inactivity due to long-term illness
   - Early retirement (before 60).

   The analysis examines six self-reported health transitions:

   - Change from 'good or excellent' health to 'fair or poor' health
   - Reported new onset of a disability or long-term health condition
   - Change from 'good' mental wellbeing to reporting a moderate to high level of mental distress
   - Onset of a disability or long-term health condition
   - Onset of limitations to amount of work an individual can do
   - Onset of limitations to the kind of work an individual can do.

   The study excludes workers who had 'fair or poor' health or a health condition or limitations at the start of the observational period. This analysis tracks 9,169 employees from the initial observational period of 2017/18, of which 25.8% (2,363 individuals) experienced a negative health transition by 2018/19. These individuals were followed through to the end of the period in 2021/22.

   This study period includes the outbreak of the Covid-19 pandemic in 2020 and its immediate aftermath – an exceptional period of disruption to the UK labour market. Our findings indicate that, despite the extraordinary circumstances, people's employment outcomes following a health decline were at similar levels to those observed in preceding years. This suggests that the issue of poor workforce retention following the onset of ill health is a persistent labour market problem and did not derive from the pandemic's unique challenges.

3. **Survey of business leaders:** The Work Foundation commissioned Survation to conduct a survey with 1,167 senior business leaders across Great Britain in May 2024 to gather insights into employer perspectives on health-related job retention and workplace support. The survey encompassed organisations from 14 sectors, all regions of Great Britain, and various sizes.

   Respondents were asked questions about their working arrangements, recruitment or retention challenges, policies on health and wellbeing, and their perceptions of the workforce health issues. A caveat of the survey was that the size of the organisation question was answered by 939 of respondents. To avoid discrepancies, whenever an average was reported for a question followed by organisation size, the adjusted sample size of 939 was used.

4. **Semi-structured interviews and roundtable discussions with employers:**

   - A roundtable in Lancaster engaged 10 North West England based employers and local stakeholders, from sectors such as transport, professional services, and construction to discuss regional challenges
   - Four semi-structured interviews were conducted to understand their specific challenges and strategic priorities in terms of the health and wellbeing of their workforce
   - Six semi-structured interviews were held with experts working on occupational health, focusing on the implementation and impact of work-health-related schemes.

3. ILL HEALTH AND THE RISK OF LEAVING EMPLOYMENT

Despite the high number of people exiting work due to ill health today, the effectiveness of measures to help them return remains limited. For many, the longer they are away from the workplace – particularly beyond the critical one-year mark – the more challenging their path back becomes.[27] Prolonged absence from work often deepens the barriers to reintegration, both psychologically and practically.

While much of the policy focus has been on supporting people back into the labour market once they have exited, there has been limited attention placed on how to keep workers in employment once their health deteriorates. Proactive interventions that support people whilst they are employed are crucial to prevent early workforce exits and its lasting impacts on an individual's future employment prospects.[28]

To examine the extent to which experiencing ill health can affect people's employment, this longitudinal analysis of Understanding Society compares the employment status of those who report a negative shift in their health status, and those who do not, following the methods used in a Department for Work and Pensions report.[29]

The analysis tracks 9,169 people who are employees at the start of the observational period in 2017/18. Among these employees, 25.8% (2,363) experienced a negative health transition between 2017/18 and 2018/19. It then follows the employment journeys of these individuals until the end of the observational period in 2021/22.

What are negative health transitions?

This analysis examines six self-reported health transitions that are reported within the Understanding Society dataset:

- Change from 'good or excellent' health to 'fair or poor' health
- Reported new onset of a disability or long-term health condition
- Change from 'good' mental wellbeing to reporting a moderate to high level of mental distress
- Onset of a disability or long-term health condition
- Onset of limitations to amount of work an individual can do
- Onset of limitations to the kind of work an individual can do.

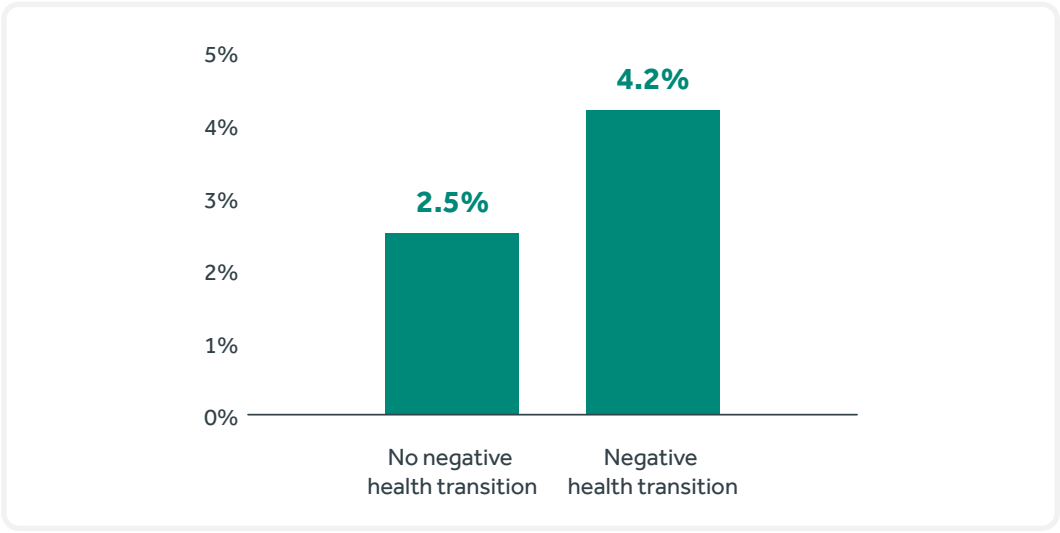
While in some cases leaving work could be considered a voluntary or positive act, this study looks at movements from employment into three types of worklessness when this follows a downturn in health: unemployment, inactivity due to long-term illness and early retirement (before 60). Although the state retirement age is 66 and any retirement before this could be classed as 'early', this analysis has demarcated exits before age 60 on the premise that this substantially shortens economic participation in a way that, when involuntary, may be particularly damaging to the future financial security of the individual and may represent a prolonged need for incapacity benefits.

The first year is critical to retaining workers after the onset of ill health

Most negative health changes are linked to an increased likelihood of leaving work, particularly in the first year of illness onset. Nearly one in ten (9%) of the employees who had experienced the onset of ill health had left work by the end of the four-year study period.

Nearly half of this attrition happened in the first year, when 4.2% employees left their job. This rate of ill health related attrition gradually decreases year on year, suggesting the first year is a critical intervention point. Men have a slightly higher ill health related attrition rate than women, with 4.7% of men leaving work in the first year after the onset of illness, compared to 3.9% for women.

Figure 3: Flow of workers aged 16-60 leaving employment depending on whether they experienced a negative health transition in one of six health measures, 2017/18 to 2018/19[i]



Source: Analysis of weighted UK Household Longitudinal Study data, 2017/18 - 2021/22.

When workers report a significant decline in their overall health, the year one dropout rate is even greater. Among employees who reported their health changed from 'good' to 'fair or poor' between 2017-18 and 2018-19, 6.4% left work within the first year. This attrition rate is more than double that of workers who had not experienced a health decline (2.4%).

For those who remain in work for two or more years after a negative health change, the rate of dropout reduces substantially, coming in line with workers without any health complaint. This suggests that once enough time has passed to enable people to have received treatment and recovered from their ill health, or, they have received interventions to make their job more manageable alongside their condition, people are better equipped to remain in the workforce.

Why the first year is important

During an initial period of ill health, a worker may be supported to stay in employment by the availability of short-term sick leave policies, such as statutory or occupational sick leave payments.

However, once these employer policies have run their course and their health has not yet recovered, individuals may feel they have no option but to leave work in order to apply for ill health and disability related benefits.

This is an important point for policymakers to note: it suggests that the critical window for people to receive interventions to support recovery and maintain employment is as soon as possible after the onset of an illness, ideally in the first year.

It also suggests that employer policies to support individuals experiencing ill health may need to allow for longer recovery and rehabilitation periods than they currently do, to keep the employment relationship open whilst people are receiving treatment or making adjustments to help them work while managing a health condition.

To ensure longer-term retention in the workforce, a more proactive and comprehensive approach is needed that takes account of evidence. Previous studies have explored which groups are more likely to become economically inactive due to ill health and the factors that contribute to their exit from the labour market.[30, 31, 32] Similarly, research has highlighted the importance of flexible working arrangements, phased returns to work, and improved access to occupational health services in supporting those with ill health.[33]

[i] When exponentiating the log values, the analysis identified that those with two conditions are 2.4 times more likely than those without any conditions to leave work, and those with three or more conditions are 5.6 times more likely to leave their job.

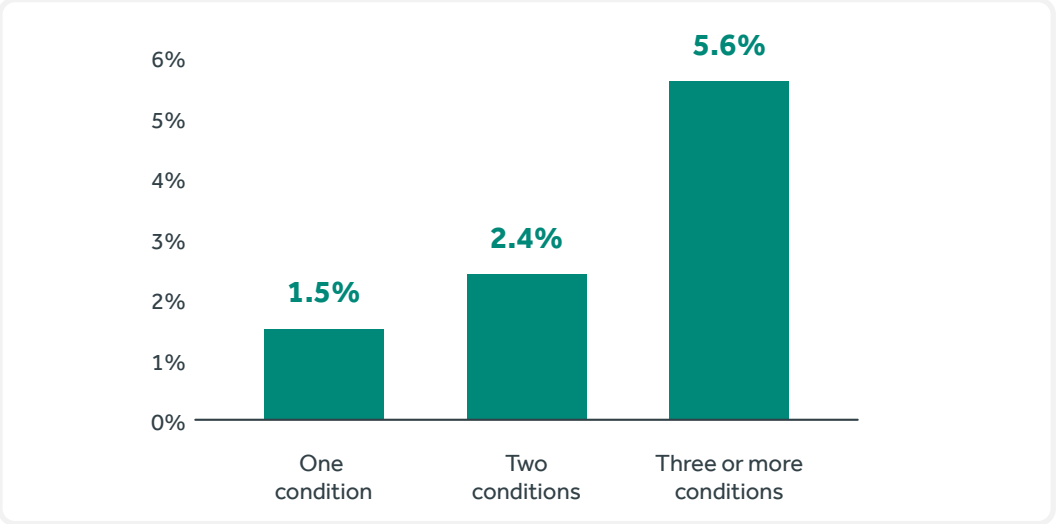
4. WHICH FACTORS INCREASE THE RISK OF HEALTH-RELATED ECONOMIC INACTIVITY?

Understanding which workers are most likely to exit the workforce due to health-related issues is crucial for designing effective interventions. Previous Health Foundation research indicates that certain groups, particularly those with multiple health conditions, face heightened risks of leaving employment, either through early retirement, long-term illness, or unemployment.[34]

Between 2017-18 and 2021-22, workers with a single disability or health condition were 1.5 times more likely than those without a health condition or disability to become economically inactive due to illness, retire early or become unemployed following any negative health transition.[ii]

However, this likelihood of leaving work increases to 2.4 times for those with two disabilities or health conditions and increases to 5.6 times for three or more conditions. This suggests that it becomes harder to maintain employment following a decline in health for people who experience multiple conditions.

Figure 4: Likelihood of leaving employment (relative risk)



Source: Analysis of weighted UK Household Longitudinal Study data, 2017/18 - 2021/22.

Although experiencing the new onset of poor mental health isn't on its own a strong driver of labour market exit per se, workers with poor mental health who experience the onset of a disability or health decline are nearly twice as likely (1.9 times) than those with good mental health to leave employment.

The association with income and early retirement

For some, health issues may lead to labour market exits recorded as "early retirement", rather than "inactive due to long-term illness".[iii] Those saving more than £280 monthly are four times more likely to retire early after a negative health event compared with those who do not save or save less than £280 per month. Income in and of itself was not a significant factor, indicating that people across all income bands face a risk of leaving work should they suffer from ill health. This counters an often-pernicious narrative that the rise in health-related economic inactivity is evidence of those at the lower end of the labour market 'shunning' work in favour of relying on benefits.

[ii] This analysis uses a logistic regression with a binary variable representing the likelihood of moving from paid employment into unemployment, early retirement or inactivity due to long-term illness. The sample includes only those workers who were employees who experienced any of the six negative health transitions. We use an indicator which specifies the number of health conditions the respondent has reported to estimate how this changes the likelihood of leaving work. Controls include demographic variables and region, and lagged variables for sector and occupational class. Standard errors are clustered by personal ID.

[iii] When surveys ask people what their employment situation is, people can only select one option. For example, they are either retired, or taking care of the family and home. However, many situations involve combinations of various states. This could mean the surveys miss out on understanding the multitude of reasons why people leave work. For instance, people may opt into early retirement due to new physical or health limitations, while for others this won't play a role. To investigate the extent to which ill health might be driving early retirement, this study examined the impact of negative health transition on the likelihood of taking early retirement.

Whilst the onset of ill health did not appear to influence early retirement rates overall, those with manual dexterity issues (problems with using their hands) were twice as likely to retire early than those without such challenges. This suggests that there may be additional health-related attrition from work which is not being captured as such in official data. Decline in manual dexterity can impact people's ability to use a computer or other equipment at work, and can be caused by conditions associated with older age such as arthritis, or the onset of a neurological conditions such as MS, as well as work-related factors such as fatigue, exposure to cold, and repetitive strain injuries.

Our findings resonate with research from the Centre for Musculoskeletal Health & Work which used econometric analysis to examine the relationship between arthritis and labour market outcomes.[35] The study's preliminary findings suggest that people with arthritis were less likely to be employed or self-employed and more likely to be retired or on long-term sick leave. While arthritis appears to have limited impact on sickness absence or unemployment, it is associated with transitions out of employment.

This is an area where early exits could be largely preventable, with better access to physiotherapy and workplace adjustments using suitable technology. The Government's Access to Work scheme aims to provide support for people with physical or mental health condition or disability. However, the uptake of Access to Work, especially for people with musculoskeletal conditions, has been low.[36] In 2017/8 there were only 6,530 approvals of Access to Work support for people with musculoskeletal conditions, highlighting the need for improving access to the scheme.

Exiting employment from different sectors

Differences in the overall work-exit rates from different sectors are fairly similar and any small variations are not statistically significant. However, as mentioned, there are different types of flow out of work, which are likely motivated (or forced) by different factors.

For example, there is a greater outflow into early retirement from industries such as education and public administration and defence and health & social work. However, it is also a significant factor in finance and insurance activities. This may be related in part to the nature of work in these sectors, which has been shown to result in more psychosocial risks with more mental ill health challenges.[37] Additionally, the traditionally more favourable terms and conditions of the pensions and voluntary redundancy or early retirement schemes on offer likely also play a role.

What are work-related psychosocial risks?

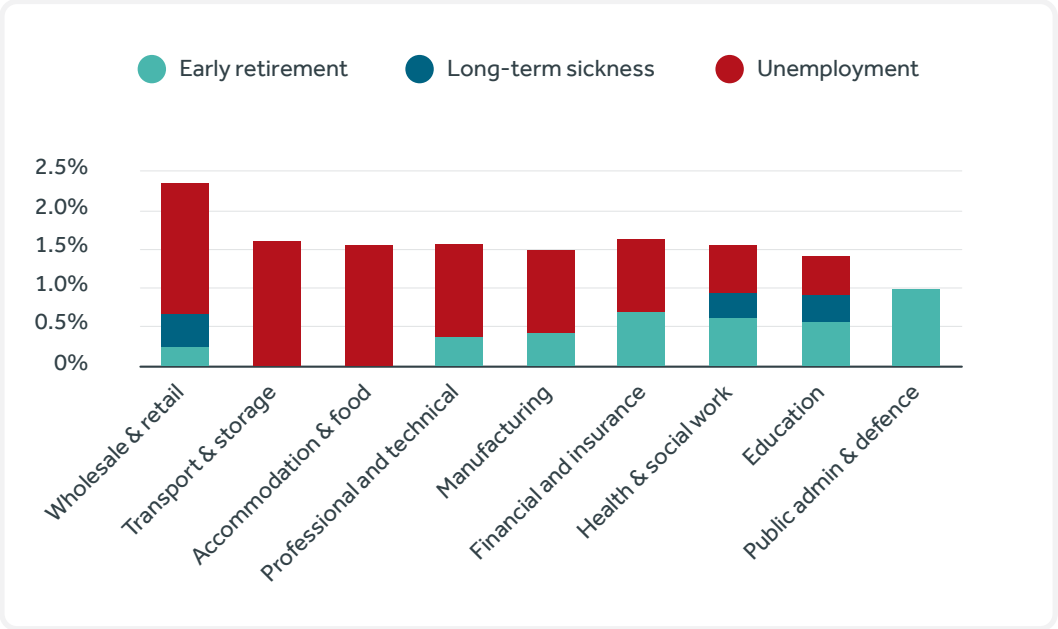
The psychosocial work environment refers to aspects of work organisation, design and management (e.g. work demands, working schedule, organisational support, rewards, organisational culture) and the interpersonal context of work. When these aspects are poorly managed, they can negatively impact worker health and organisational sustainability.

Psychosocial risks include unrealistic job demands, high workload and work pace, long working hours, inflexible working schedule, job insecurity, lack of role clarity, role conflict, lack of trust and psychological safety, lack of organisational and interpersonal support, harassment, bullying and interpersonal conflicts in the workplace. These risks affect both physical and mental health, and result in both short and long-term sickness absence, presenteeism, reduced productivity, human error, increased disability pensions and healthcare costs, and early retirement.[38, 39, 40, 41]

Exit from paid employment from a given sector into unemployment is more pronounced in sectors in which insecure work tends to be concentrated. Previous Work Foundation analysis found that insecure workers were 1.4 times more likely than secure workers to exit work.[42] This is likely due in part because insecure roles are often of shorter duration and there is a greater risk of being (temporarily) unemployed.

Unfortunately, the sample sizes for the flow into long-term inactivity due to illness is too small to report for most sectors, even with the pooled sample across five waves. For the sectors reported on, there was no significant association between sectors and the likelihood of leaving work and becoming long-term sick.

Figure 5: Flow from sectors showing transitions out of paid employment (combined those with and without health transition)



Source: Analysis of weighted UK Household Longitudinal Study data 2017/18 - 2021/22., pooled sample.

A lack of flexibility at work can heighten the risk of exiting the labour market

While the specific sector an individual works in when experiencing ill health may not significantly impact their chances of leaving employment, the work environment and working conditions do appear to have a substantial bearing.

Between 2017-18 and 2021-22, workers who had no flexibility at work at all were four times more likely to leave work than those who have access to any of eight different types of flexibility, including part-time work, flexitime, annualised hours, compressed hours, job sharing, working remotely, working term-time only, or 'other' flexible working arrangements.

This builds on previous research that has shown that flexibility is an important incentive to remain, or return to work, specifically for older workers.[43] Some flexibility may be informally organised in workplaces, but in many cases, the use of flexible work is obtained through an official request and when granted, leads to a contractual agreement.

This new analysis shows that 'other flex' is the only form of flexibility which significantly reduces the likelihood that someone will leave employment after a negative health event in the models. This means that people do not identify their individual arrangement as any of the options listed above, but they do acknowledge they are working in a flexible way. None of the other more 'official' forms of flexibility are a particularly important predictor of the risk of leaving work. However, there is a difference in the likelihood of exit between those who have 'any' kind of flexibility at the workplace compared with those who do not have any flexibility at all. Workers with no flexibility at all are 1.7 times more likely than those with 'any' flexibility to leave work after a negative health transition.[iv]

Lack of 'control' risks pushing people out of work

The extent to which workers feel they have control over their work in terms of job tasks, work pace, work manner, task order and work hours can also be decisive.

Analysis of Understanding Society data for this period suggests that having no, or low levels of control across these five dimensions of work made people 3.7 times more likely to leave work after the onset of a negative health experience. In contrast, having 'a lot' of autonomy over at least one aspect of work reduced the chances of leaving by nearly three quarters. This aligns with the wider literature,[44] indicating that people who feel more in control over aspects of their job, such as the hours they work, or how they perform their tasks, makes people less likely to leave following a negative health event.[v]

There are differences between men and women regarding which dimensions of work control matter most to them.

- Women are 2.4 times more likely to leave work if they have no control over the order in which they carry out tasks, compared to those who do.
- For men, control over task order is less important but they are five times more likely to leave work after a negative health event if they lack control over how they do their work.[vi]
- Life phase is particularly important for men. Men aged over 50 are six times more likely to leave work if they lack control over how they do their work.[vii]

This highlights there is not a 'one size fits all' approach to job design, but shows the different ways in which workers can exert control over their working lives can be important retention factors to specific groups of workers in specific phases of their lives.

Once you leave the labour market due to ill health, it can be hard to return

As outlined in the previous section of this report, evidence indicates that both poor health and labour market exits can be highly challenging to reverse. Department for Work and Pensions evidence shows that approximately half of people recover from the onset of poor health within two years.[45] This means that half of people take much longer to recover, with the likelihood of recovery declining each year. Data indicates that approximately a quarter of people have persistent poor health even after six years and that recovery from poor health is associated with an increased probability of returning to work.

[iv] This analysis used a logistic regression with a binary dependent variable representing the likelihood of moving from paid employment into unemployment, early retirement or inactivity due to long-term illness, and estimate using a lagged variable how the use of flexible work options influences this likelihood. The sample includes only those workers who were employees who experienced any of the five negative health transitions. Controls included demographic variables and region, and lagged variables for sector and occupational class. Standard errors are clustered by personal ID.

[v] This analysis used a logistic regression with a binary dependent variable representing the likelihood of moving from paid employment into unemployment, early retirement or inactivity due to long-term illness, and estimate how a lagged scale of autonomy influences this this likelihood. The sample includes only those workers who were employees who experienced any of the five negative health transitions between 2017/18 and 2018/19. Controls included demographic variables and region, and lagged variables for sector and occupational categories. Standard errors are clustered by personal ID.

[vi] This analysis used a logistic regression run separately on men and women with a binary dependent variable representing the likelihood of moving from paid employment into unemployment, early retirement or inactivity due to long-term illness, and estimate with lagged dummy variables for the five work control dimensions how these influences this likelihood. The sample includes only those workers who were employees who experienced any of the five negative health transitions. Controls included demographic variables and region, and lagged variables for sector and occupational class. Standard errors are clustered by personal ID.

[vii] Same as above but conducting heterogeneity analysis by age group.

5. EMPLOYERS SUPPORTING WORKERS EXPERIENCING ILL HEALTH TO REMAIN IN THE WORKFORCE

To improve workforce health and employment outcomes for people experiencing poor health, policymakers must understand the challenges workers and employers face. Analysis in this report makes clear that support within the first year after the onset of an illness or disability, as well as improving access to flexible work arrangements and increasing job control and autonomy, can play a key role in helping people sustain employment.

To examine how policy can better equip employers to support more people experiencing ill health to remain in the workforce, this section draws on a survey of British business leaders and in-depth discussions with employers and policymakers. It explores the challenges employers face in improving workplace health and the changes that are likely to be needed if the UK is to achieve what one participant from a transportation company in North West England termed as a "need for a national reset on workforce health".

Understanding employer perspectives on workforce health

Absentee rates are often used as a proxy measure for ill health at work. More than four in ten (44%) senior British business leaders identified absenteeism due to ill health as a serious issue within their organisations.[viii] This is a more prevalent issue among large organisations (250+ employees), among whom 55% cite absenteeism as a significant issue, compared to 37% of SMEs, suggesting that large organisations may be more affected by or more aware of the impacts of absenteeism.

Approximately two-thirds of respondents (64%) acknowledge that poor employee health has a detrimental effect on their organisation's economic performance. Notably, 34% of businesses were aware of the increasing prevalence of mental health conditions, particularly in the health (44%), manufacturing (43%) and education (40%) sectors.

Employers surveyed acknowledged several workplace factors that can exacerbate health issues within an organisation:

- 75% reported excessive workloads
- 73% reported long-working hours
- 74% reported lack of breaks and paid leave
- 69% reported lack of clarity about job roles
- 65% reported unpredictability at work.

It should be noted that these factors all fall squarely within employers' control. They also represent psychosocial risks to worker health, business sustainability and societal wellbeing, and are increasingly recognised as the number one priority in the future of work.[46, 47] However, the reality is private sector employers might feel compelled to adopt less-than ideal-working practices to remain competitive in the market in the short term, or the public sector might need to respond to service demands or cuts to their budgets. In this context, it is the role of Government policy and legislation to set clear and appropriate standards, ensuring that market pressures do not serve as an excuse for employers less inclined to adhere to higher standards on their own.

[viii] The sample size relevant to questions concerning the size of the organisations totals 939.

Short-term vs long-term absences: diverse challenges

Employers identify that there are different approaches needed in managing short-term versus long-term sickness. An HR Director from a national charity employing more than 1,100 people highlighted concerns about the amount of time an employee might be away from work without contact with their employer:

> **"We are getting far more people being signed off for a very long time. In the past the longest I would find someone signed off with and particularly for stress or anxiety or other sorts of mental health illnesses, would be about a month. Whereas recently we've been seeing people signed off for two months. That's an awful long time to be out of your business and out of contact with your colleagues and your manager."**

Discussions with employers uncovered two assumptions for why long-term absences may be prevalent: delays in medical appointments and treatments due to extended NHS waiting times and the increasing prevalence of mental health issues, which are often unpredictable and fluctuate significantly. For these types of absences, employers put an emphasis on the need to maintain contact with employees and offer flexible ways back into working life, that might include changed working patterns.

By contrast, employer concerns around short-term absences included the worry that sickness absence was being used as a way for people to cope with other issues in their lives, such as financial hardship and the costs of commuting or difficulties accessing childcare. Pay and conditions, and wider public service infrastructure, therefore become important elements in supporting workers at the lower end of incomes to maintain employment.

Awareness and readiness to support people with long-term health conditions

Two thirds of employers (66%) surveyed said their organisation feels ready to actively support people who are out of work due to long-term health conditions back into employment. This readiness varies notably by organisation size, with 59% of SMEs feeling prepared compared to 77% of large organisations.

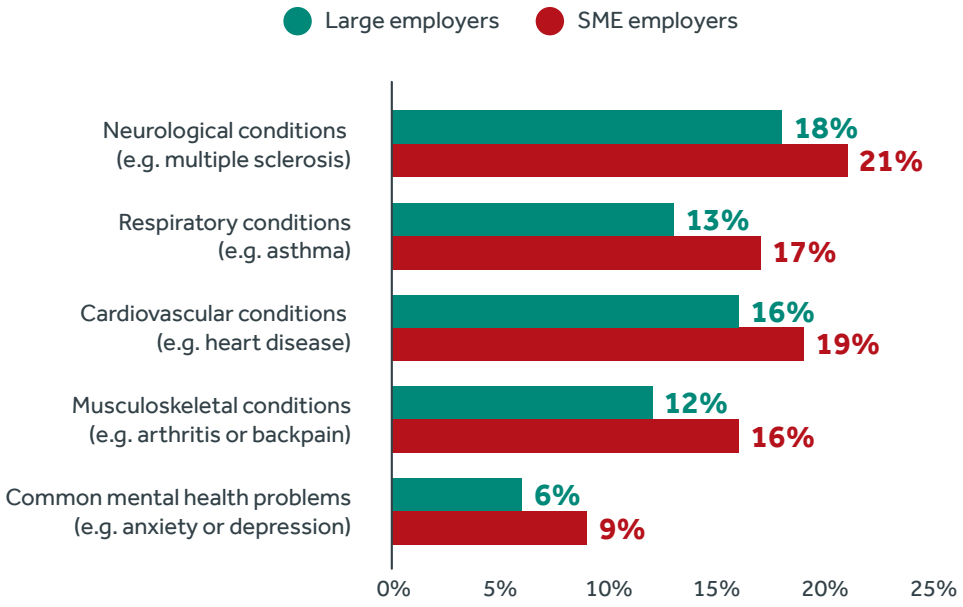
Organisations struggling with staff recruitment are more likely to feel prepared to support employees with long-term health conditions, with 71% expressing readiness. In contrast, organisations that do not face recruitment and retention issues report lower readiness, with only 53% feeling prepared to offer necessary support. This highlights the central importance of employee retention and support when there are wider staffing challenges.

The data also reveals significant disparities in employer readiness to support various health conditions, highlighting areas where workplace health and wellbeing support can be enhanced. While there is generally strong preparedness to support mental health conditions, certain physical health issues – such as neurological and cardiovascular diseases – pose greater challenges, particularly for SMEs. Neurological conditions like multiple sclerosis (MS) present the most significant difficulties, with 21% of SMEs and 18% of large employers feeling less equipped to provide adequate support. Given that there are more than 150,000 people with MS in the UK,[48] many of whom are in work or who want to work, there is a need to improve employer understanding of conditions like these that can have invisible and fluctuating symptoms.

There is also notable concern regarding support for musculoskeletal (MSK) conditions like arthritis and back pain, with 16% of SMEs and 12% of large organisations reporting a lack of readiness, despite the fact that MSK conditions are prevalent among the workforce and were the second highest cause of days lost in 2023.[49] Similarly, when it comes to readiness for supporting employees with cancer, research by the Institute for Employment Studies reveals that many organisations still fall short in providing adequate information, training, and support to their HR and line management teams.[50]

These findings point to a need for targeted training and resources to improve employer capabilities in managing a diverse range of health conditions effectively, and with confidence. However, it is also important to note that generic training and resources would be insufficient in some circumstances, especially where there might be employer liability concerns about someone working while unwell. To safely manage employees with complex or serious health conditions, employers would require occupational health advice on a case-by-case basis, such as guidance on fitness to work and appropriate adjustments.

Figure 6: Employers who are not confident in supporting workers' with various health conditions



Source: Work Foundation analysis of nationally representative survey of senior business leaders across Great Britain, unweighted total: 1,167.

The awareness to action gap

A majority of employers understand that a supportive working environment can lead to better outcomes such as employee job satisfaction and improved retention and productivity – and there has been progress in the extent to which health and wellbeing are discussed in work. A senior leader from a large bus company has noted a positive shift in the way these responsibilities today compare with 20 years ago when "you didn't bring your problems to work, you just left them at the door." He continues:

> **"We look at both employee engagement and wellbeing and also diversity and inclusion [...] Now we understand that whatever goes on at home has an impact on how you feel at work and how you feel at work has an impact on your home life. We try and look at it holistically too, to make sure that people are supportive or supported in all aspects of life... When we get into actually a sickness and absence, then it becomes an operational issue."**

Some employers mentioned good practices in conducting stress risk assessments, but it is unclear whether any changes are implemented as a result, due to overstretched services. An adult social care provider for people with complex needs, employing over 10,000 staff told us:

> **"We do have stress risk assessments that take place as well and they are done on a company level basis, in terms of measuring risks and deciding whether you need to be more proactive. (But when it comes to intervening) "It's very difficult to get an occupational health provider that's able to obviously assess people and a lot of the time support workers are having to take time out of their work or plan because we can't let the people we support to be at a disadvantage with no care."**

Some businesses are also taking proactive measures to support time off for employees, though they acknowledge there is still a stigma about mental health-related absence. A medium sized bank employing over 400 people in office-based jobs, report that they "provide additional days off that are designed to support their work life balance and life outside of work" such as paid wellbeing and volunteering days.

Despite this positive shift in attitudes, there can remain a disconnect between awareness and action. While half of respondents (51%) believe employers bear some responsibility for the decline in employee health, many are struggling to implement effective measures to address the issue.

This disconnect between identifying the issue and taking concrete action is also visible in how specific policies are implemented. A detailed examination of health and wellbeing policies reveals varied implementation across upstream, midstream, and downstream measures:

- **Proactive health measures:** Only over one-third of employers recognise the importance of upstream measures like assessing mental health risks (36%) and adjusting work to ensure proper workload and pace (37%). Implementation of these policies appears to remain a challenge with 40% of large sized organisations and 34% of SMEs report having these policies in place in although these are mandated by the HSE.
- **Occupational health services:** More than three in five employers (65%) acknowledge the value of occupational health services and their role in maintaining employee health. Yet only 37% of employers actually provide these services. Large sized employers are more likely to offer occupational health services than SMEs (47% versus 30%).
- **Flexible working arrangements:** The most commonly adopted policy is flexible working, with 48% of organisations offering flexible working arrangements at the time of this survey conducted. Flexibility is particularly linked to retention in the longitudinal analysis, but the survey data does not indicate which types of flexibility are available or to what portion of the workforce.

The data shows that while there is strong awareness of the importance of health support, implementation lags significantly, particularly in smaller organisations. This issue was echoed in discussions with policymakers, who highlighted the limited capacity of SMEs to invest in areas like occupational health, workplace entitlements such as sick pay and leave, and broader HR provisions.

Figure 7: Percentage of employers providing the following health and wellbeing policies

Type of measure	Policy	All	SME employers	Large employers
Upstream	Assess mental health risk and adjust work to ensure appropriate workload, work pace and role clarity	36%	34%	40%
	Adjust work organisation to ensure workload, work pace and role clarity	37%	38%	34%
	Assess health risks associated with on-site work environment	34%	32%	38%
	Assess health risks associated with remote work environment	28%	25%	34%
	Operate a shorter work week across the organisation	25%	23%	28%
Midstream	Offer flexible working hours (i.e. part time, compressed hours, flexitime)	48%	49%	46%
	Adjust work environments for people with disabilities	39%	35%	44%
	Provide occupational health services	37%	30%	47%
Downstream	Provide enhanced sick leave payment	26%	23%	29%
	Provide fitness centre membership	27%	22%	35%
	Provide paid or part-paid sabbaticals	22%	19%	26%

Source: Work Foundation analysis of nationally representative survey of senior business leaders across Great Britain, unweighted total: 1,167.

RAND Europe's research, commissioned by the Government's Work and Health Unit, also sheds light on the barriers faced by SMEs, arriving at similar concerns.[51] The study finds that while 70% of SMEs provide proactive health promotion, targeted support for specific health conditions is less common. SMEs are more likely to adopt more informal approaches to workplace health. The primary barriers to investing in health and wellbeing support for SMEs are lack of expertise (49%), time or resources (49%), and capital (52%).[52] The study also found that SMEs showed equal preference for choosing preventative health schemes and those targeted at employees with health conditions. Additionally, SMEs are more likely to participate in health schemes with higher financial reimbursements.

It is important to mention that these challenges are not unique to the UK. Employer surveys across European Union countries have shown similar findings that employers, and particularly SMEs, are not implementing changes to manage workforce health effectively, especially in relation to addressing mental health at work.[53, 54, 55] For instance, a study by the European Agency for Safety and Health at Work found that European micro and small enterprises encounter comparable challenges in implementing health and wellbeing policies.[56] This reinforces the need for coordinated efforts to bridge the gap between awareness and action in protecting workforce health across the economy.

Managers can play a critical role, but they need support too

In addition to organisational policies, managers can play a critical role in creating a positive psychosocial work climate and supporting employees with health conditions. During conversations with employers and occupational health practitioners, the importance of managerial support was frequently highlighted, particularly in helping employees navigate health challenges while maintaining their employment. Another study conducted in EU countries found that workplaces that foster an open climate for discussing mental health issues saw significantly better mental health outcomes among employees compared to those that did not.[57]

Research from the Chartered Management Institute (CMI) reinforces this point. A poll conducted with managers found that flexible working options, including remote and hybrid work, were cited by over 60% of managers as one of the top three most important factors in encouraging employees to return after a period of sickness absence. This was followed up by a positive and inclusive work culture (43%) and the availability of support options, such as coaching, mentoring, and peer support networks (32%).[58] However, nearly two-fifths (39%) of managers reported facing challenges aligning job expectations with the capabilities of employees returning from long-term sickness absence.[59] Additionally, 37% noted that employees often experience fear or anxiety about job security upon returning to work, highlighting the need for managers to provide reassurance and support during these transitions.

While training and supporting managers are critical in achieving a supportive work culture, recent research on the role of managers in supporting workers in insecure jobs also found that managers often feel limited in the way they can support employees. Therefore, there is a need to improve the work culture from top to bottom and give guidelines to employers through regulations.

6. INTERNATIONAL POLICY LESSONS

Given the evidence in this report regarding the kinds of workplace factors and risks that are contributing to the rise in ill health related exits from the UK labour market, significant policy and practice reform is needed if this trend is to be reversed.

In order to consider the kinds of change required, the following section uses a framework of upstream, midstream and downstream measures to review a range of policy interventions adopted by other nations, each aimed at supporting healthier working practices and the overall health of their working age populations.

Upstream: Job quality

The quality of employment plays a significant role in determining health outcomes, and in turn, an individuals' ability to remain in work over the long-term. Good quality work has been associated with improved health and wellbeing,[60] while poor quality work can adversely impact health outcomes.[61, 62]

At the structural level, the UK can improve job quality by strengthening regulatory frameworks. Action in this area is underway – for example the recent tabling of the Employment Rights Bill contains provisions to make flexible working the default and a day one right.[63] However, the Government's current proposals on flexible working still allow employers considerable discretion in granting these rights.

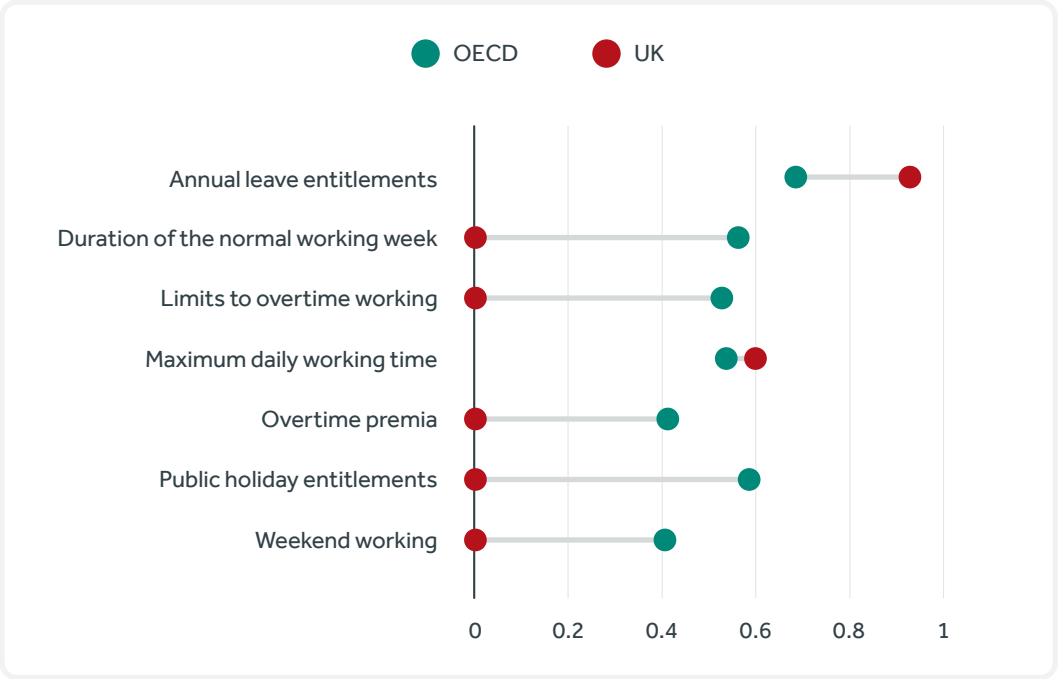
Under European Union law, the right to request flexible work only covers carers and parents of children aged eight and under.[64] However, some European countries have chosen to exceed the requirements of both the EU and the UK.

Finland, for example, is considered a world leader on flexible work.[65] In 1996 it passed the Working Hours Act, which allowed most workers to choose their start and end times within a three-hour window.[66] This led to an estimated 92% of companies offering flexible working arrangements by 2011.[67] In 2019, Norway passed new legislation granting most workers the right to work remotely for at least half of their working hours.[68] By contrast, research by the Work Foundation found that 48% of UK employers report offering flexible work.

Promoting healthy work environments also means ensuring that regular working hours provide sufficient time away from work.[69] Yet, the UK ranks among the bottom 11 out of 41 OECD nations for employees working very long hours, with one in ten employees (11%) doing so – slightly higher than the OECD average.[70] Despite the UK scoring better than the OECD average for annual leave entitlements, it performs poorly on nearly all other metrics related to the regulation of working time compared to other OECD nations.

According to the TUC, the UK has some of the weakest working time laws in the developed world.[71] The figure below shows a comparison of a range of working time regulations between the UK and the OECD, scored from 0, where these regulations are not in place, to 1, where these are very strongly regulated.

Figure 8: Regulation of working time in the UK compared with the OECD average, 2022



Source: Work Foundation calculations of Deakin, S., Armour, J., & Siems, M. (2023). CBR Leximetric Datasets [Updated 2023]. Apollo - University of Cambridge Repository. https://doi.org/10.17863/CAM.9130.2

Under the UK's current system, workers have the option to opt to work more than the UK's 48-hour working week limit, a measure that has long been criticised for potentially jeopardising workers health and safety.[72] Employers are also not required to pay for overtime as long as a worker's average hourly pay does not fall below the minimum wage.[73]

To address this policy failing, the UK could take inspiration from France which enforces a 35-hour weekly working time limit, rising to a maximum of 48-hours with overtime.[74] Statutory rules dictate that workers must be paid 125% of their salary for the first eight hours of overtime and 150% thereafter. Working week regulations have been found to generate significant increases in job and leisure satisfaction among French workers, both of which are key drivers of worker health.[75, 76, 77] However, a review conducted on the suitability of similar regulation for the UK economy found that a public sector-first approach is more suitable, alongside wider support for employer-by-employer rollouts of reduced hours.[78]

Given the growing evidence linking job quality to health outcomes, the Health and Safety at Work etc Act 1974 could also be updated to ensure employer responsibilities reflect the evolving challenges of today's workforce, especially in relation to work intensification, increased challenges around psychosocial risks and mental ill health at work and changes in working practices. The findings in this report highlight that employers need support to implement legal requirements on assessing risks for mental ill health in a preventative manner and put in place appropriate measures. While this is similar to the approach of other countries, there is a trend of updating existing legislation, and providing further tools and guidance.[79] The HSE's establishment of an evidence base to guide policy decisions that can help employers prevent and mitigate work-related stress is a welcome development.

Midstream: Occupational health (OH)

The UK complies with the trend among English-speaking nations in not placing legal requirements on employers to provide occupational health (OH) services to their employees, in contrast to many European nations where some form of OH provision is mandatory.

Under the UK's voluntary approach, 45% of workers have access to occupational health provisions, and only 37% of employers offer OH services.[80] In comparison, in Germany, Denmark and the Netherlands where OH provision is mandatory, there is close to universal coverage amongst workers.[81]

Figure 9: International comparisons – public healthcare, occupational health systems, and employer responsibilities[x]

	Primarily market driven OH provision, funded by employers	Public/ private OH provision primarily funded by employers	Public/private OH provision primarily funded by employers and the state	Basic state funded OH services and voluntary private sector delivered OH services for employers.
Mandatory Occupational Health (OH) Legally mandated employer occupational health requirements	Germany Netherlands	France Denmark	Poland* Japan Finland	
Voluntary OH Universal, free at the point of use, tax-funded healthcare system (HS)	Canada United Kingdom*			
Voluntary OH Universal, primarily tax funded, subsidised HS	Australia			Republic of Ireland*

**Denotes country has a publicly funded healthcare system.*

The previous Conservative Government did take some steps to address UK workers limited access to occupational health services. In 2015, the Government rolled out the Fit for Work service, which provided occupational health assessments and advice to employees, employers, and GPs to help individuals start in or return to work. Analysis of the programme found that participants in the scheme spent longer in work and less time in receipt of out of work benefits.[82] However, the service was scrapped in 2018 due to low referral rates.[83]

Introducing a more proactive approach to worker health – such as mandatory OH requirements – could lead to improved employee health, lower levels of sickness absence, and reduced healthcare costs.[84] The UK could learn from other European nations by enacting mandatory employer OH provisions, with the challenge being consistent implementation across organisations of all sizes. It is also important to note that in countries such as Finland and Italy, small and medium-sized enterprises have access to regional OH services from which the UK could learn. [85]

Midstream: local government interventions

Local government plays a key role in supporting worker health by leveraging local knowledge and relationships with key stakeholders to enact health-promoting policies tailored to the needs of their local communities.[86, 87] However, the power held by local governments in the UK is considerably lower than regional governmental bodies in other comparable nations.[88] With regard to health promotion, the efforts of local government in the UK are often hampered by national directives stifling local priority setting.[89]

In contrast, in Denmark, local municipalities are responsible for health promotion and prevention, but have no specific requirements on how to achieve this goal or which services to prioritise.[90] The current Government has committed to devolving greater powers to local government. This initiative should explicitly provide greater powers over health, if the UK is to address the ingrained challenges present in many local labour markets.

[x] The analysis in this table builds upon the findings of the 2021 Department for Work & Pensions report International comparison of occupational health systems and provisions.

Downstream: Support for workers in ill health

Tackling the UK's economic inactivity dilemma also involves reassessing the levels and delivery of financial support to people unable to work due to ill health.[91]

The UK's Statutory Sick Pay (SSP), paid by employers, is currently set at £116.75 per week up to 28 weeks. While proposals in the Employment Rights Bill to remove the lower earning cap and four-day waiting period are positive, SSP remains one of Europe's least generous, replacing just 17% of average weekly earnings.[92] Research by the Work Foundation shows almost half of employers (47%) do not go beyond the statutory minimum level of sick pay provision.[93] SSP is also inflexible, as it does not allow employees to receive a combination of sickness benefits and normal wages, creating a financial disincentive for employees to consider a phased return to work.[94]

Figure 10: European sick pay policies

Country	Sick pay policy
Germany[95]	Workers who have been employed continuously for four weeks before falling ill receive full pay from their employer for six weeks if they are unable to work. Following this, health insurance companies provide sick pay rated at 70% of a person's salary. Workers may claim the sick pay for 78 weeks (incl. six weeks paid by their employer) over a three-year period, for the same illness.
France[96]	Sick pay commences after three days. The state provides 50% of the daily basic wage (max €52.28 per day). If an employee has worked at a company for more than a year, their employer must top up the benefit to 90% of their salary for the first 30 days of sickness, and 66.66% of their salary for the next 30 days. Length of service and collective bargaining agreements can increase the period for which employers must top up a worker's sick pay benefit to up to six months.
Italy[97]	Statutory Sick Pay is not provided for the first three days of sickness, although most employment contracts include employer provision for this period. Between day four and day 20 of illness statutory sick pay amounts to 50% of average daily pay, increasing to 66.66% thereafter. There is a limit of 180 days per calendar year.
Poland[98]	Polish employers continue to pay their employees for the first 33 days of sick leave per calendar year (or 14 days if the worker is over 50), after which it is paid by the state. Sick pay is generally paid for up to 182 days. Depending on the nature of illness, payment rates cover either 80% or 100% of a worker's wages.

Some nations enact a far more flexible approach to sick pay provision. In Finland, workers who are unable to perform their regular duties, but can undertake reduced or modified tasks through part-time work, may still qualify for partial sick allowance, amounting to 50% of the full benefit. Independent academic analysis of this policy has found it generally reduces the period of sickness absence and enhances return to work and participation.[99, 100] In comparison to full sick leave, partial sickness benefits in Finland have been found, when not followed by a lasting return to work, to be more typically followed by partial disability pension and less frequently by full disability pension. Indicating the policy might, in part, slow the flow into permanent and full disability benefits.[101]

Employer responsibility toward their employees is also greater in other nations. For example, in the Netherlands, employers must provide sick pay of at least 70% of worker's wages for first two years of an absence.[102]

7. A NATIONAL RESET ON WORKFORCE HEALTH

The UK is an international outlier in terms of the rise in economic inactivity due to ill health, with 2.78 million people affected – an increase of over 671,000 since the pre-pandemic period.[103] While other comparable nations have returned to pre-pandemic labour market participation levels, the UK continues to grapple with a persistent health-related inactivity crisis.

This report's analysis shows that **negative health changes are strongly linked to an increased likelihood of leaving work. This is particularly evident in the first year following the onset of an illness, suggesting that once sickness absence schemes finish, people leave the job and, in many cases, the labour market altogether.**

The analysis also reveals that workers with **two health conditions or disabilities are 2.4 times more likely to enter economic inactivity, enter early retirement or unemployment due to illness,** compared to those without such conditions. **For those with three or more health conditions, this likelihood jumps to 5.6 times.**

A lack of flexibility and control significantly exacerbates this issue. **Workers with no flexibility are four times more likely to leave employment when they fall ill.**

There are critical gaps in the current support systems designed to help people stay in employment when facing health challenges. Workers in low paid or insecure roles, are particularly vulnerable, as they often lack access to Statutory Sick Pay (SSP). This leaves them at greater risk of financial hardship and job loss when health issues arise.

Even workers with access to paid sick leave are at risk of falling out of employment once these benefits are exhausted. The current system does not adequately address the longer-term support needs of those recovering from or managing ongoing health conditions.

Policy interventions must focus on closing these gaps to ensure that all workers – regardless of income level or contract type – have access to adequate support helping them remain in the workforce and maintain financial stability during periods of poor health.

A new policy framework should address the following aims:

- **Protect workforce health:** acknowledging that employment models, environments and employer decisions are a critical determinant of population health, and that proactive action can minimise the risks.
- **Increase workforce retention and reduce pressure on the welfare system:** strengthen protections when health transitions occur, supporting more people to remain economically active and maintain a connection to work.
- **Achieve a fair and sustainable sharing of responsibility:** ensure the financial implications of long-term ill health are shared between employers and the state, and that people have liveable incomes even if their capacity to work is reduced.

CONCLUSIONS AND RECOMMENDATIONS

On 10 October 2024, the Government published the long-anticipated Employment Rights Bill offering substantial new protections for workers. These include the introduction of day-one employment rights, the banning of exploitative zero-hour contracts, and the strengthening of SSP.

These measures are essential to addressing the harms of poor-quality work, however, years of policy inaction have taken their toll, contributing to today's troubled labour market where people are leaving in great numbers due to ill health. While the Government is under pressure to weaken proposed new protections, the evidence in this report underscores how important control, flexibility and security over working arrangements are to people with health issues.

To reach the ambitious target set by the Secretary of State for Work and Pensions, Liz Kendall MP, of an 80% employment rate – a five percentage points increase – urgent steps must be taken to improve the retention of people in work.

It is encouraging that the Government's 'Get Britain Working' White Paper has sought to embed a cross-department approach to improving workforce health. The recently announced Mayhew Review into how employers themselves need to adapt policies and practices to boost workforce retention is a further welcome step. The analysis in this report has made clear the importance of establishing a roadmap to implement a series of upstream, midstream and downstream interventions in the years ahead, to help ensure more people remain in health, sustainable employment. Measures should include:

Upstream action – to improve job quality and strengthen health forecasting, Government should:

a) **Ensure the Employment Rights Bill enshrines secure and flexible working from day one of employment.** Any exceptions that allow employers to deviate from new regulations must be reduced to maximise the number of workers able to benefit from flexible working and guaranteed hours. The onus should be put on employers to advertise what forms of security and flexibility they are offering.

b) **Enhance and enforce paid leave entitlements to meet workforce needs as pension age rises.** Legal entitlements to paid leave must address care, health, and recuperation needs, including paid time off for caring and healthcare appointments. Statutory holiday and break entitlements must be enforced, ensuring fairness across incomes and contracts. Pilots should be rolled out of enhanced time-off models (e.g. self-rostering, reduced work weeks, sabbaticals) in the NHS and public sector to evaluate impacts on health and retention, promoting broader adoption.

c) **Update the Health and Safety at Work etc Act 1974.** Ensure employer responsibilities address today's workforce challenges, including psychosocial risks, mental ill health, and evolving work practices. Strengthen the HSE's role in supporting employers to assess mental health risks and implement preventative measures.

d) **Modernise workforce health data by improving forecasting and monitoring.** Establish a cross-governmental approach to key indicators, integrating HSE reporting with new datasets, such as HMRC's real-time working hours data from 2025. Require large employers to report health-related data; including attrition, 48-hour week opt-out rates, and risk assessments of physical and mental work-related harm.

Midstream action – to develop a roadmap for transformed occupational health services and integration with public health, Government should:

e) **Lead a strategic transformation of occupational health services to improve and extend coverage to all workers, with mandatory provision by large employers.** Promote depth and quality of services, requiring the involvement of registered medical professionals and a focus on preventative action including for mental health. Consider tax incentives for employers demonstrating positive outcomes.

f) **Establish a UK-wide network of one-stop workforce health hubs, offering funded SME services and integrated public health.** Mayoral Combined Authorities could coordinate hubs, drawing on local authority and NHS integrated care board initiatives. This not-for-profit model could build on DWP Work Well pilots and the Access to Work Mental Health Support Service, to provide employers, especially SMEs, with publicly funded occupational health provision. The focus should include mental and physical health, with targeted support for people who are at risk of leaving work. To build trust, hubs must be protected from political cycle churn.

Downstream action – to prevent exclusion of long-term sick employees from the workforce, Government should:

g) **Increase Statutory Sick Pay (SSP) to support retention.** The Employment Rights Bill's proposal to increase SSP reach by abolishing the income threshold and waiting period are welcome, but £116.75 per week remains too low to provide a meaningful safety net. To prevent people working while ill, or prematurely leaving the workforce, the Government should create a roadmap to raise SSP to 60% of wages or the Real Living Wage, pro-rated by hours worked, whichever is highest.

h) **Consider extending employers' duty of care and incentivising vocational rehabilitation.** Roll out a vocational rehabilitation approach with statutory guidance on revising roles, hours, and work locations, in consultation with employees and health professionals. To address the cliff edge when SSP runs out but there has not yet been a full health recovery, employers should offer a phased return-to-work, allowing part-time hours supported with wages and sick pay. Government could extend employer SSP obligations beyond 28-weeks if reintegration plans are inadequate.

i) **Test feasibility of partial wage subsidy and SSP rebates to offset employer long-term sickness costs.** Government could provide SSP rebates, prioritising SMEs, tied to welfare budget savings if demand for ill health benefits stabilises. Longer-term models of cost sharing could aim to subsidise wages in cases where health conditions or disabilities require reduced hours or prolonged absence.

Implementing new workforce health protections requires Government action and upfront investment, but care must be taken to ensure changes are practical and sustainable, allowing employers time to adapt. While additional costs are inevitable, a detailed review should be conducted into how they can be even shared and offset by the benefits of a healthier, more resilient workforce and reduced pressures on the NHS and welfare system.

Failing to act decisively will only intensify the challenges the UK faces: rising ill health among workers, a heightened rate of attrition, increased labour shortages, which all have costs attached. It is therefore critical that any new initiatives are designed and funded for the long term, ensuring the UK achieves a healthier workforce able to contribute to the economy today and into the future.

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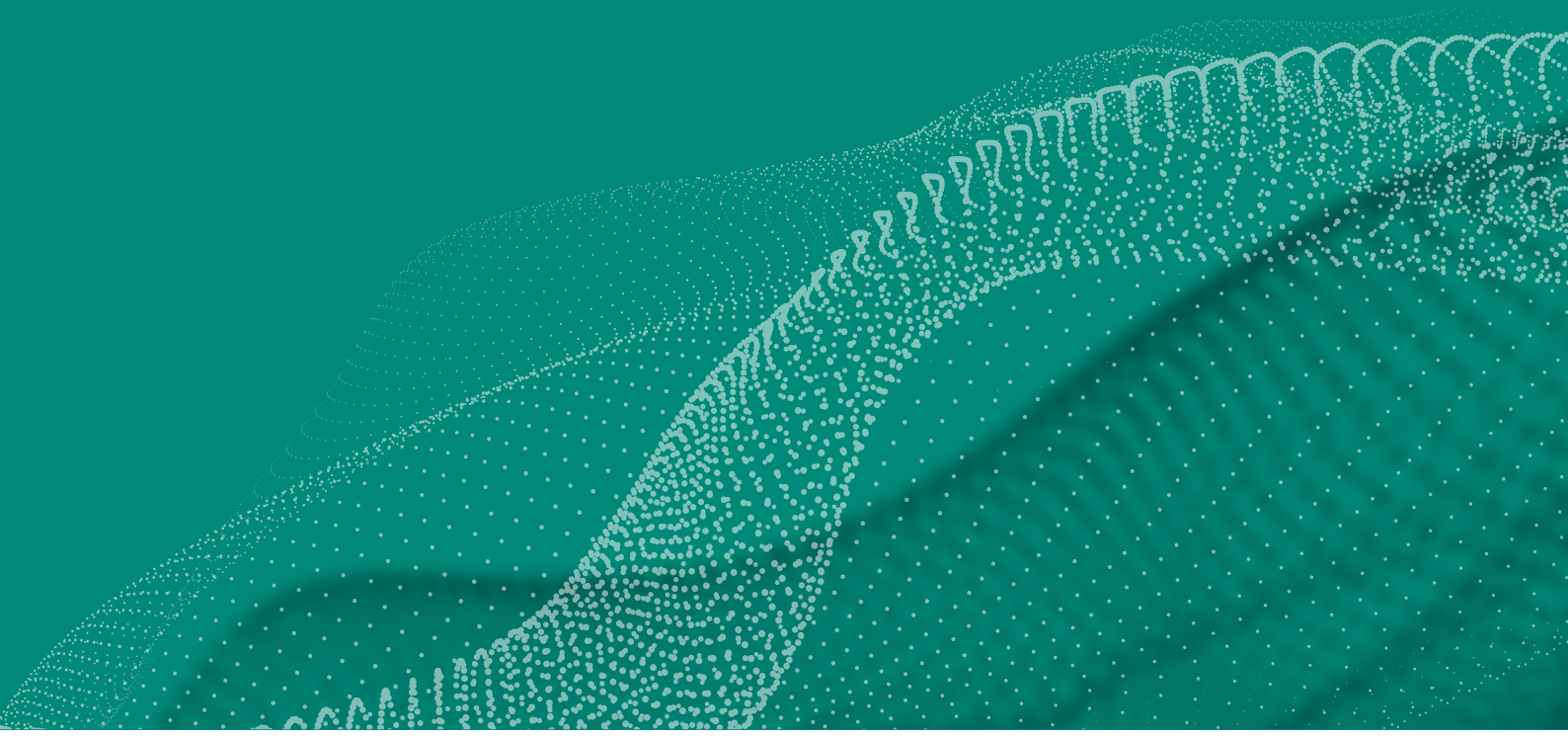

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